DEPARTMENT OF HEALTH AND HUM/*1 SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICA **SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ 495358 B. WING 04/16/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8830 VIRGINIA STREET **AMELIA NURSING CENTER** AMELIA, VA 23002 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION 1D (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** OATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F.000 INITIAL COMMENTS F 000 An unannounced Medicare/Medicaid standard survey was conducted 4/15/15 through 4/17/15. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements The Life Safety Code survey/report will follow. The census in this 100 bed certified facility was 96 at the time of the survey. The survey sample consisted of 20 current resident reviews (Residents #1 through #17 and #23 through #25) and 5 closed record reviews (Residents #18 through #22). F 164 483.10(e), 483.75(I)(4) PERSONAL F 164 SS=D | PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the RECEIVED release of personal and clinical records to any individual outside the facility. MAY 0 1 2015 The resident's right to refuse release of personal and clinical records does not apply when the VDH/OLC resident is transferred to another health care institution; or record release is required by law. LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZH6F11

Facility ID: VA0002

PRINTED: 04/23/2015

PRINTED 04/23/2015 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES QMB_NO_0938-9391 STATEMENT OF DEFICIENCES (X1) PROVIDERISUPPLIERICLIA (XZ) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION ICENTIFICATION NUMBER COMPLETED A BUILDING 495358 9 WING 04/16/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS CITY STATE ZIP CODE 8830 VIRGINIA STREET AMELIA NURSING CENTER AMELIA, VA 23002 SUMMARY STATEMENT OF DEFICIENCIES (N (PX3) iš i PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (K5) DOMPLE REW PREFIX PREFIX SEACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION; CROSS-REFERENCED TO THE APPROPRIATE IAG DATE DEFICIENCY; F 164 Continued From page 1 F 164₁. LPN #1 was given 1-1 04/21/15 The facility must keep confidential all information counseling about providing contained in the resident's records, regardless of privacy for residents receiving the form or storage methods, except when invasive medications release is required by transfer to another healthcare institution; law; third party payment procedures and also asking contract; or the resident. residents prior to medication administration, where they would prefer to receive their This REQUIREMENT is not met as evidenced oral medications. 04/29/15 2. All LPNS and RNs have Based on observation, resident interview, steff received education on privacy interview, and cfinical record review, it was during medication determined that the facility staff failed to provide personal privacy for two of six residents during administration and asking the the medication administration observation, residents' preference Residents #13 and #14 where they prefer their oral medication to he Resident #13 was administered an injection. administered 04/29/15 into the abdomen with her abdomen exposed 3. A protocol for administration while in the room with the door open. of medications to include 2. Resident #14 was administered medication by privacy and residents mouth and choked in the dining room, while in the preference has been reviewed presence of other residents by the QA Committee and approved. All LPNS and RNS The findings include: have been educated on the 04/29/15 new protocol. 1. Resident #13 was administered an injection Medication pour and pass into the abdomen with her abdomen exposed while in the room with the door open. observations conducted by the QA Nurse Resident #13 was admitted to the facility on on a monthly basis and 3/20/13 with diagnoses that included but were not reported to the QA limited to: diabetes (elevated blood sugar), kidney Committee quarterly. disease and high blood pressure. Resident #13's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference

cognitively intact.
FORM CMS-2507[02-98] Previous Versions Obsolem

date) of 3/23/15, coded the resident as being

Event IC: 2H6F11

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If continuation shield Page 2 of 37

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PRINTED: 04/23/2015 FORM APPROVED

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AMELIA N	URSING CENTER			8830 VIRGINIA STREET AMELIA, VA 23002	
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F 164 Continued From page 2

F 164

On 4/16/15 at 8:12 a.m., observation of LPN (licensed practical nurse) #1 administering an injection into Resident #13's abdomen was conducted. The resident's shirt was pulled up, exposing a portion of her abdomen. The injection was administered in the resident's room with the door open. No privacy curtain was drawn. A housekeeping employee was observed mopping the floor in another resident room directly across the hall.

On 4/16/15 at 10:35 a.m., an interview was conducted with LPN #1. LPN #1 was asked the process for providing privacy while administering an abdominal injection. LPN #1 stated she gives injections in residents' rooms and she pulls the privacy curtain if someone else is in the room. LPN #1 was then asked if she leaves the door open. LPN #1 stated, "I should have shut the door."

On 4/16/15 at 12:55 p.m., an interview was conducted with Resident #13. The resident was asked how she felt about receiving an injection into her abdomen with the room door open. Resident #13 stated sometimes she doesn't like it.

On 4/16/15 at 6:20 p.m., the administrator and director of nursing were made aware of the above findings. A policy regarding this matter was requested. The policy provided was titled, "ADMINISTRATION OF MEDICATIONS" and falled to document any pertinent information regarding privacy during medication administration.

2. Resident #14 was administered medication by

FORM CMS-2567/03-99; Previous Versions Obsolute

Event ID 7H6F11

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If continuation sheet Page 3 of 37

PRINTED: 04/23/2015 FORM APPROVED OMB NO. 0938-0391

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(X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATE SURVEY COMPLETED

495358

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04/16/2015

NAME OF PROVIDER OR SUPPLIER

AMELIA NURSING CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE 8830 VIRGINIA STREET AMELIA, VA. 23002

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SUMMARY STATEMENT OF DEFICIENCIES FEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION?

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DEFICIENCY)

COMPLETION CALL

F 164 Conlinued From page 3

mouth and choked in the dining room, while in the presence of other residents.

Resident #14 was admitted to the facility on 7/10/13 with diagnoses that included but were not limited to: high blood pressure and heart disease. Resident #14's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/14/15, coded the resident's cognition as being severely impaired.

On 4/16/15 at 8:00 a.m., observation of LPN #1 administering medication to Resident #14 in the dining room was conducted; other residents were present in the dining room. At this time, Resident #14 began coughing for approximately five seconds while attempting to swallow her pills. The resident was able to finish taking her medication after the coughing ceased.

On 4/16/15 at 10:30 a.m. a group interview was conducted will! 13 residents. Three residents stated they receive medication in the dining room.

On 4/16/15 at 1:50 p.m., an Interview was conducted with LPN #1. LPN #1 stated the nurses administer inhalers, nasal sprays and injections in resident rooms but usually administer pills in the dining room or day rooms if residents are okay with that. When asked how she knew if residents were comfortable with receiving pills in the dining room, LPN #1 stated the nurses will ask. LPN #1 confirmed she did not ask Resident #14 if she was comfortable receiving her medication in the dining room that morning.

On 4/16/15 at 2:20 p.m., an interview was conducted with Resident #14. At this time, this

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FORM CMS 2507(92-99) Previous Versions Obsolers

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Facility ID: VA0D02

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F 164	observed receiving room that morning. when I choked." Reshe felt about receiv room. Resident #14 getting it too." Whe get her medication i	ge 4 he resident that she had been her medication in the dining Resident #14 stated, "Yeah; sident #14 was asked how ving medication in the dining I stated, "Everybody else is n asked if she would prefer to n private, Resident #14 n me back down here (to the	F 16	id		
	director of nursing was findings. A policy represented. The policy and administration falled to document a regarding privacy duadministration.	TO SURVEY RESULTS -	F 16	7		
	the most recent surv Federal or State surv correction in effect w The facility must mail examination and must	ght to examine the results of ey of the facility conducted by reyors and any plan of ith respect to the facility. The results available for some post in a place readily onto and must post a notice of		1. 2.	State Survey and moved closer to front door so it will be easily accessible. Notices will be placed in admission packet for families and residents as to location of state survey results.	0S/01/2015
	examination and muraccessible to reside their availability.	si post in a place readily nts and must post a notice of			to location of state survey results. Activities Director will continue to bring up location of state survey results at every Resident Council	1

FORM CAS-7567(02-99) Previous Versions Obspice

This REQUIREMENT is not met as evidenced

Based on observation, resident interview, staff interview and clinical record review, it was

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survey.

Meeting. All residents will sign

acknowledgment of location of

If continuation sheet Page 5 of 37

PRINTED: 04/23/2015 FORM APPROVED 391

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F 167 Continued From page 5

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determined that the facility staff failed to post a notice regarding the availability of survey results

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LECTOENTHYING IMPORMATION)

The findings include:

On 4/15/15 at 12:50 p.m. and 4/16/15 at 11:25 a.m., observation of the facility's 2014 survey results was conducted. The results were located in a green folder on the wall next to the entrance into the front lobby. The front of the folder was labeled, "2014." No further notice of the survey results was documented on the folder or anywhere else in the lobby.

On 4/16/15 at 10:30 a.m., a group meeting was conducted with 13 residents. When asked if they knew where the survey results were located, five residents stated, "Yes" and the other residents shook their heads.

On 4/16/15 at 11:50 a.m., an interview was conducted with CNA (certified nursing assistant) #1 regarding availability of survey results. CNA #1 stated the administrator kept the survey results in her office and staff could ask to look at them. When asked how residents and visitors had access to the survey results, CNA #1 stated, "I wouldn't know how to answer that." When asked if any notice of survey results was posted. CNA #1 stated, "In the employee lounge."

On 4/16/15 at 11:55 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated the survey results were located in the green folder at the door and residents were made aware of that during the resident council meetings.

F 167 3. Mandatory in-service will be given by QA/Administrator for all staff to ensure everyone knows where the most recent state

survey is located.

(SACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY

4. Administrator will check weekly for placement of state survey to make sure it is easily accessible.

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Event ID: ZH6F11

Facility ID: VANKU

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PRINTED: 04/23/2015 FORM APPROVED OMBINO 0938-2334

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AMELIA N	URSING CENTER			8830 VIRGINIA STREET AMELIA, VA. 23002	
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F 167 Continued From page 6

On 4/16/15 at 6:20 p.m., the administrator and director of nursing were made aware of the above findings. A policy regarding this matter was requested.

On 4/17/15 at 9:06 a.m., an interview was conducted with Resident #23. Resident #23 was admitted to the facility on 3/3/15 with diagnoses that included but were not limited to; high blood pressure, osteoporosis (a bone disease) and a urinary tract infection. Resident #23's most recent MDS (minimum data set), a 14 day Medicare assessment with an ARD (assessment reference date) of 4/1/15, coded the resident as being cognitively infact. Resident #23 stated she did not know where the survey results were located in the facility.

On 4/17/15 at 9:16 a.m., an interview was conducted with Resident #25. Resident #25 was admitted to the facility on 5/2/14 with diagnoses that included but were not limited to: muscle weakness, urinary tract infection and breast cancer. Resident #25's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/8/15, coded the resident as being cognitively intact. Resident #25 stated sine did not know where the survey results were located in the facility.

No further information was presented prior to exit. F 226 483.13(c) DEVELOP/IMPLMENT

SS=D ABUSE/NEGLECT, ETC POLICIES

The facility must develop and implement written policies and procedures that prohibit mistrealment, neglect, and abuse of residents and misappropriation of resident property.

F 167

F 226

FORM CMS-2567(62-99) Previous Versions Obsolele

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If continuation sheet Page 7 of 37

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DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES						: 04/23/201
		& MEDICAID SERVICES						APPROVE 0938-039
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F 226	Continued From pa		F 22	26	1.	100% audit of all currer staff ensuring the impler of abuse policies and p for abuse in regards to employees prior to hire.	mentation rocedures	05/01/2015
	by:	IT is not met as evidenced				employees prior to file.		
	Based on staff inter review, and employed determined that the implement abuse po- abuse in regards to hire for one of five e- new hires from the fi	view, facility document are record review, it was facility staff failed to plicies and procedures for screening employees prior to mployee records reviewed of ast four months; Other Staff Speech Language Therapist.			2.	All new hires for therapscreened according to procedure for abuse an license verification for Virginia Department of Professions will be placefacility in Rehab Director this is to be signed off	oolicy and d copy of rom the of Health d in file at ors office, each time	05/01/2015
	verification was obta	ole to evidence a license lined for OSM #4, who was til requested on survey			3.	by Office Manager/HR Nursing and Rehabilitation In-service Therapy (Rehab Management, importantance of	on Center Company (nc) on	04/29/2015
	The findings include:					screening of all ne		• •
	new hires from the la conducted. OSM #4	's record did not contain a om the Virginia Department				according to policy and p for prevention of abuservice to be given by Office Manager/HR to program manager of company.	use. In- Business HR and	
	Administrator, she state (rehabilitation) compadepartment and do a She stated the rehabilicense verification but	.m., in an interview with the ated that the rehab any staffs the therapy li the checks and screens. facility provided them with a at it was dated 4/16/15 and was done at the time of hire.			4.	All present therapy staf new hire for therapy signed off by Amelia Nu Rehabilitation Center	will be arranged and	05/8/2015

IRM CMS-7564(GR-SW) Provides Versions Objection

An email was provided from the rehab company

that documented, "his the practice of Human Resource to verify therapist have a clean license

Event to 290515

Facility ID VA0002

(File to be kept by Program Manager)

If continuation sheet Page 8 of 37

PRINTED: 04/23/2015 FORM APPROVED OMB NO. 0938-0391

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AMELIA NURSING CEI	VTER	1	30 VIRGINIA STREET VELIA, VA. 23002	
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F 226 Continued From page 8

with no dings on it through the state Office of the inspector General and preform (sic) a license Source Verification through Dept of Health as a condition of pre-employment. In the case of (OSM #4) the onboarding agent may have been somewhat overzealous and did not print the Source Verification Screen at the time of viewing. Under no circumstances can any candidate be keyed into the (system) employee system/data base without this verification being performed. (System) requires all new hire onboarding be audited by HR, any discrepancies in requirements would have been caught at that time if the employee had any red flags against their license..."

A second email from the therapy company documented, "We always verify therapist have a clean license with no dings on it through the state Office of the Inspector General and a licensure Source Verification through Dept of Health as a condition of pre-employment and annually thereafter."

A review of the facility policy "Screening of Potential New Hires" documented, "License and certified personnel shall have their ficense verified with the State Board of Nursing (sic) an area is available on the application to record verification."

No further information was provided by the end of the survey.

F 241 483.15(a) DIGNITY AND RESPECT OF SS=D INDIVIDUALITY

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in

F 226

04/21/15

F 241

1. LPN #1 was counseled 1-1 regarding the failure to administer medications to Residents #13 and #14 in a way that maintained their dignity and respect in full recognition of their individuality.

FORM CMS-7567(03-96) Physicial Versions Obusinia

Event (0:2) (8F1)

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AMELIA NURSING CEN	i EK	***************************************	AMELIA, VA 23002	
DARLES SUMME	RY STATEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF CORRECT	'ION - CO

F 241 Continued From page 9

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full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR USC IDENTIFYING INFORMATION)

Based on observation, resident interview, staff interview and clinical record review, it was determined that the facility staff failed to provide dignity and respect for two of six residents during the medication administration observation. Residents #13 and #14.

- 1 Resident #13 was administered an injection. into the abdomen with her abdomen exposed while in the room with the door open. When interviewed about this, Resident #13 stated sometimes she doesn't like it.
- 2. Resident #14 was administered medication by mouth and choked in the dining room, while in the presence of other residents. When asked if she would prefer to get her medication in private, Resident #14 stated, "Yeah. Bring me back down here (to the room)."

The findings include:

1. Resident #13 was administered an injection into the abdomen with her abdomen exposed while in the room with the door open.

Resident #13 was admitted to the facility on 3/20/13 with diagnoses that included but were not limited to: diabetes (elevated blood sugar), kidney disease and high blood pressure. Resident #13's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/23/15, coded the resident as being

F 241

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2. All LPNs and RNs have received in-04/29/15 service education on resident dignity and respect of individuality.

(EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY

3. A protocol for administration of medication has been instituted after review by the QA Committee. outlines the necessity to allow the resident to make choices on where they will take their medications. As well as providing privacy for those residents receiving invasive procedures in order to maintain their dignity. All nurses have been educated on this protocol.

Medication pass pour and observations will be conducted monthly by the QA nurse and reported to the QA committee at the quarterly meetings.

04/29/15

04/29/15

CONNECTIONS NOT SOME DESIGNATION OF STREET

Event ID: ZH6F11

Facility ID: VA0002

If continuation sheet Page 10 of 37

PRINTED: 04/23/2016 FORM APPROVED OMB NO. 0938-0301

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AMELIAN	UKSING CENTEK		Carriera	AMELIA, VA 23002	
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F 241 Continued From page 10 cognilively intact.

On 4/16/15 at 8:12 a.m., observation of LPN (licensed practical nurse) #1 administering an injection into Resident #13's abdomen was conducted. The resident's shirt was pulled up, exposing a portion of her abdomen. The injection was administered in the resident's room with the

was administered in the resident's room with the door open. No privacy curtain was drawn. A housekeeping employee was observed mopping the floor in another resident room directly across

the hall.

On 4/16/15 at 10:35 a.m., an interview was conducted with LPN #1. LPN #1 was asked the process for providing privacy while administering an abdominal injection. LPN #1 stated she gives injections in residents' rooms and she puls the privacy curtain if someone else is in the room. LPN #1 was then asked if she leaves the door open. LPN #1 stated. "I should have shut the door."

On 4/16/15 at 12:55 p.m., an interview was conducted with Resident #13. The resident was asked how she felt about receiving an injection into her abdomen with the room door open. Resident #13 stated sometimes she doesn't like it.

On 4/16/15 at 6:20 p.m., the administrator and director of nursing were made aware of the above findings. A policy regarding this matter was requested. The policy provided was titled, "ADMINISTRATION OF MEDICATIONS" and failed to document any pertinent information regarding dignity and respect during medication administration.

F 241

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If continuation sheet Page 11 of 37

DEPARTMENT OF HEALTH AND HUWAN SERVICES CENTERS FOR MEDICARE & MEDICARE & MEDICARE

PRINTED: 04/23/2015 FORM APPROVED OMB NO: 0938-0351

CENTE	<u>RS FOR MEDICARE</u>	8 MEDICAID SERVICES	**************************************		OMB NO. 0938-035
STATEMENT OF DEFICIENCIES AND PLAN OF COFFRECTION		(XI) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER	i	IPLE CONSTRUCTION 19	(X3) DATE SURVEY COMPLETED
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F 241		s administered medication by in the dining room, while in the		†1	
	7/10/13 with diagno limited to: high bloo	admitted to the facility on uses that included but were no d pressure and heart disease at recent MDS (minimum data	,		;

On 4/16/15 at 8:00 a.m., observation of LPN #1 administering medication to Resident #14 in the dining room was conducted; other residents were present in the dining room. At this time, Resident #14 began coughing for approximately five seconds while attempting to swallow her pills. The resident was able to finish taking her medication after the coughing ceased.

set), a quarterly assessment with an ARO (assessment reference date) of 1/14/15, coded the resident's cognition as being severely

On 4/16/15 at 10:30 a.m. a group interview was conducted with 13 residents. Three residents stated they receive medication in the dining room.

On 4/16/15 at 1:50 p.m., an interview was conducted with LPN #1 LPN #1 stated the nurses administer inhalers, nasal sprays and injections in resident rooms but usually administer pills in the dining room or day rooms if residents are okay with that. When asked how she knew if residents were comfortable with receiving pills in the dining room, LPN #1 stated the nurses will ask. LPN #1 confirmed she did not ask Resident #14 if she was comfortable receiving her medication in the dining room that morning.

On 4/16/15 at 2:20 p.m., an interview was

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If continuation sheet Page 12 of 37

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PRINTED: 04/23/2016 FORM APPROVED OMB NO. 0938-23801

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	PROVIDER OR SUPPLIER NURSING CENTER		Contract of the contract of th	8830	EYADDRESS. CITY STATE, ZIP CODE VIRGINIA STREET LIA, VA. 23002	A 4000 Miles and 1000
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F 278 SS=D	surveyor stated to the observed receiving room that morning, when I choked." Reshe felt about receive room. Resident #14 getting it too." Whe get her medication it stated, "Yeah. Bring room)." On 4/16/15 at 6:20 processed, The policy requested. The policy requested. The policy rerequested. The policy rerequested in document a regarding dignity and administration. 483.20(g) - (j) ASSE ACCURACY/COOR! The assessment muresident's status. A registered nurse meach assessment with participation of health. A registered nurse meassessment is compiled.	ident #14. At this time, this he resident that she had been her medication in the dining. Resident #14 stated, "Yeah; sakent #14 was asked how ring medication in the dining. I stated, "Everybody else is in asked if she would prefer to in private, Resident #14 me back down here (to the own, the administrator and here made aware of the above garding this matter was by provided was titled, "OF MEDICATIONS" and my pertinent information of respect during medication. SSMENT DINATION/CERTIFIED stracturately reflect the ust conduct or coordinate the appropriate in professionals, ust sign and certify that the eted.	F 24	1.	RN #2 has reviewed the RAI Manual regarding the need for a mood interview for Resident #9. RN #2 voiced understanding for the need of an interview. An audit of all current quarterly and annual MDS was completed by the MDS coordinator and MDS assistant in order to check for any other possible interview errors.	04/27/15 04/29/15
	Under Medicare and	Medicaid, an individual who			manual when in doubt.	- Andrewson - Andr

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If continuation sheet Page 13 of 37

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCES

STATEMENT OF DEFICIENCES

AND PLAN OF CORRECTION

(X1) PROVIDERISUPPLIERICLIA (X2) MALTIPLE CONSTRUCTION
(X3) DATE SURVEY COMPLETED

495358

B WIND

NAME OF PROVIDER OR SUPPLIER

AMELIA NURSING CENTER

STREET ADDRESS CITY STATE ZIP CODE

8830 VIRGINIA STREET AMELIA, VA 23002

(Xd) () PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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04/16/2015

F 278 Continued From page 13

willfully and knowlingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowlingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:

Based on staff interview and clinical record review the facility staff failed to ensure a complete and accurate MDS (Minimum Data Set) for one of 25 residents in the survey sample, Resident # 9.

The facility staff failed to conduct the resident interview for mood on a quarterly MDS (Minimum Data Set) assessment for Resident #9.

The findings include:

Resident # 9 was admitted to the facility on 8/9/13 with a readmitted on 9/14/14 with diagnoses that included but were not limited to: dementia (a group of symptoms caused by disorders that affect the brain.), herpes simplex (infection that is caused by a herpes simplex virus), lumbar compression fracture (broken vertebrae). Vertebrae are the bones of the spine), esophageal reflux (when a muscle at the end of your esophagus does not close properly it allows stomach contents to leak back, or reflux, into the esophagus and irritate it.), dysphagia (a swallowing disorder), acute respiratory failure

F 278

4. The QA Committee will review compliance at the quarterly meeting.

04/29/15

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If continuation sheet Page 14 of 37

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PRINTED: 04/23/2015 FORM APPROVED

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Medicare/Medicald Services) RAI Version 3.0								

FORM CMS-2567(02-99) Previous Versions Obsolete

Conducted?

Manual" documented,

Steps for Assessment

*D0100: Should Resident Mood Interview Be

Event ID: ZH6F11

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if continuation sheet Page 15 of 37

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DEPARTMENT OF HEALTH CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				TIPLE CONSTRUCTION	FOR OMB N (xs) D	PRINTED: 04/23/20 FORM APPROVI OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
THE RESIDENCE OF THE RESIDENCE OF	. WINGO 1 V WANNESS, A SHIMA WANNESS OF THE STATE OF THE THE THE STATE OF THE STATE	495358	B WING	and the second s		4/16/2015	
	PROVIDER OR SUPPLIER NURSING CENTER			STREET ADDRESS CITY STATE 8830 VIRGINIA STREET AMELIA, VA 23002		The second secon	
(×a) (t) PREFIX TAG	(EACH DEFICIENC)	NEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREFI TAG	PROVIDERS PLAN X (EACH CORRECTIVE) CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	COLEMA (SEL)	
F 278	understood. If rarely D0500, Staff Asses (PHQ-9-OV©). 2. Review Languag the resident needs communicate with c (A1100 = 1). If the resident need complete the interview Coding Instructions Code 0, no: if the inconducted. This optivesidents who are rawho need an interprinct available, Skip to	resident is rarely/never y/never understood, skip to sment of Resident Mood e item (A1100) to determine if or wants an interpreter to doctors or health care staff ds or wants an interpreter, ew with an interpreter. Interview should not be ion should be selected for arely/never understood, or reter (A1100 = 1) but one was	F 2	78			

The Administrator and DON were made aware of these findings on 4/16/15 at approximately 6:20

Code 1, yes: if the resident interview should be conducted. This option should be selected for residents who are able to be understood, and for whom an interpreter is not needed or is present. Continue to Item D0200, Resident Mood Interview

No further information was provided prior to exit. F 323 483.25(h) FREE OF ACCIDENT SS-5 HAZAROS/SUPERVISION/DEVICES

> The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

04/17/2015

1.Maintenance Director called F 323 O'Neal's Electrical to assist in finding thermostat adjustment dial on Hydrocullator after adjusting thermostat temperatures are running 160 degrees daily.

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(PHQ-9@),"

EventiOtZNoF11

Facility ID VA0002

If continuation sheet Page 16 of 37

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		& MEDICAID SERVICES	1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		<u>MB NO, 0938-039</u> T
	OF DEFICENCIES SECORRECTION	IDEATIFICATION NUMBER INTO PROVIDER/SUPPLEM/CLM	l .		CONSTRUCTION	(XJ) BATE SURVEY COMPLUTED
		495358	& WING			04/16/2015
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AMELIA	NURSING CENTER			883	O VIRGINIA STREET	
984748878887-1487-W-18-11-11-11-11-11	non M. M. et		1944 W S.S. Stranson M. Yu, S	AM	ELIA, VA 23002	elementario de la companio del companio de la companio della compa
(84) (0 1996) 48 7AG	(LACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE INSCRIBED BY FULL SC IDENTIFYING INFORMATION:	PR(ED) TAG		PROVIDERS PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD GROSS-REFERENCED TO THE APPROP DEFICIENCY)	IEE COMMETIKAN
F 323	Continued From pa	ge 16	F3	23		
	by.	T is not met as evidenced			2. Temperature will be checked ever morning and documented of temperature log by rehab staff. And temperature above 166 degrees will be reported to Program Manager.	
	interview and clinical determined that the the hydrocollator (a and heating pads) to manufacturers' insti-	ion, resident interview, staff al record review, it was facility staff failed to maintain device containing hot water emperature per the ructions, for four of 25 yey sample, Residents #3.			3. Program manager will in-service at Rehab staff on correct temperatures for Hydrocollator 160-166 degrees Program Manager to be made aware of any temperatures higher than 160 degrees and Hydrocollator will be taken out of service immediately.	r f 5
	were 170 degrees, instructions docume	hydrocollator temperature The manufacturers' anted the recommended are of 160 to 166 degrees.			4. Daily Temperature log will be signed off by Program manager and Maintenance Director weekly.	
	The findings include	<u>:</u>				
	hydrocollator in the conducted. At this to member) #1, a rehawas asked to take to inside of the hydrocoread 170 degrees.	i p.m., observation of the rehab department was time, OSM (other staff b (rehabilitation) technician he temperature of the water billator. The thermometer OSM #1 was asked to provide collator manufacturers.				
	the hydrocollator wa	a.m., another observation of s conducted. At this time, to take the temperature of				

FORM CME 2567(42-99) Provious Versions Observa

the water inside of the hydrocollator. The thermometer read 170 degrees. When asked what the temperature was supposed to be, OSM #1 stated, "Anywhere between 160 degrees and

Event ID: ZH6FH

Facility ID: VA0002

If continuation sheet Page 17 of 37

PRINTED: 04/23/2015 FORM APPROVED OMB NO. 0938-0391

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F 323	conducted with OSI rehabilitation. OSM manufacturers' instruction in the lamberature of the lamberaturers' instruction. The there and the slightest adtemperature severa recommended oper (degrees Fahrenheit)" OSM running 170 degrees this time, this survey hydrocollator tempe	i a.m., an interview was M #2. The director of I #2 was asked what the ructions were regarding the hydrocollator. OSM #2 stated 60 degrees and 170 was shown the ructions that documented, Y INSTRUCTIONS: 2. Impostat is extremely sensitive justment will alter the I degrees. The ating temperature is 160 to 166 (degrees M #2 stated, "Oh. It's been is and a little bit under." At yor requested the April 2015 reture log and a list of receiving hot packs from the					
	4/1/15- 171 degrees 4/2/15- 171 degrees 4/3/15- 171 degrees 4/6/15- 171 degrees 4/7/15- 170 degrees 4/8/15- 170 degrees 4/10/15- 171 degree 4/13/16- 171 degree 4/15/15- 171 degree 4/15/15- 170 degree 4/16/15- 170 degree	S S S S S					
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with some without Millionson commoncers. When you		495358	B Wing	The second secon	04	/16/2015
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F 323 Continued From page 18

F 323

Review of the list of residents receiving hot pack therapy revealed four residents were receiving hot packs. The following interviews were conducted with those residents:

Resident #3 was admitted to the facility on 5/25/13 with diagnoses that included but were not limited to: anxiety, osteoporosis (a bone disease) and muscle weakness. Resident #3's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 3/24/15, coded the resident's cognition as being moderately impaired. On 4/17/15 at 8:23 a.m., an interview was conducted with Resident #3. Resident #3 confirmed she was receiving hot pack therapy and stated the not packs felt good.

Resident #23 was admitted to the facility on 3/3/15 with diagnoses that included but were not limited to: high blood pressure, osteoporosis and a urinary tract infection. Resident #23's most recent MDS, a 14 day Medicare assessment with an ARD of 4/1/15, coded the resident as being cognitively intact. On 4/17/15 at 9:06 a.m., an interview was conducted with Resident #23. Resident #23 confirmed she was receiving hot pack therapy and stated the hot packs felt good.

Resident #24 was admitted to the facility on 6/13/13 with diagnoses that included but were not fimited to: osteoporosis and high blood pressure. Resident #24's most recent MDS, a quarterly assessment with an ARD of 1/30/15, coded the resident as being cognitively intact. On 4/17/15 at 9:15 a.m., this surveyor attempted to interview Resident #24 but the resident was involved in an activity.

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If continuation sheet Page 19 of 37

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	TUP DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PRESTRUCTION BORE	(X3) DATE SURVEY COMPLIED
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F 323	Continued From pa	ge 19	F	323	
	5/2/14 with dragnos limited to; muscle winfection and breast recent MDS, a quar of 2/8/15, coded the intect. On 4/17/15 a conducted with Resconfirmed she was Resident #25 stated warm at first but fell to the weight and he on 4/16/15 at 6:20 pdirector of nursing winfection.	idmitted to the facility on es that included but were not reakness, urinary tract cancer. Resident #25's most terly assessment with an ARD resident as being cognitively at 9:16 a.m., an interview was ident #25. Resident #25 receiving hot pack therapy. If the hot packs were a little good after her legs got used eat.			
F 371 88=F	483.35(i) FOOD PR STORE/PREPARE/S The facility must - (1) Procure food from	on was presented prior to exit. OCURE, SERVE - SANITARY m sources approved or ory by Federal, State or local	F 3	1a. All dietary staff provided restraints/nets to wear in the kitchen during food prep and s Anyone not wearing proper restraints will not be allowed in kitchen prep area.	main 04/17/2015 erve. hair
		istribule and serve food tions		 Meat Slicer taken apart cleaned per procedure for cle meat slicer. 	i
	by Based on observation	This not met as evidenced on, staff interviews and facility withe facility failed to prepare		1c. fans immediately removed kitchen and clean dust free fa their places. Dietician to pr procedure for proper storage of during preparation.	ns in ovide 04/27/2015

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AMELIA NURSING CENTER AMELIA NURSING CENTER SUMMANY STATEMENT OF PROJECTS AMELIA VA 2 3002 F 371 Continued From page 20 and serve food in a sanitary manner. 1) Facility staff failed to wear hair restraints in the main kicken during food preparation and serving. 2) Facility staff failed to properly clean food service equipment. 3) Facility staff failed to properly clean food was free of dust and debris from a nearby fan. The findings include: 1) On 4/15/15 at 11:52 a.m., the kitchen lour was conducted. On 4/15/15 at 11:52 a.m., an observation was made that OSM (other staff member) # 3, the dietary manager was not wearing the appropriate hair restraint. On 4/16/15 at 11:52 a.m., an observation was made that OSM # 4 when asked for hair restraint. On 4/16/15 at 12:30 p.m., OSM (other staff member) # 3, a house-respondent of the kitchen without wearing a hair net, bicket up a tray of food from a preparation table and walked back out of the kitchen without wearing a hair net, bicket up a tray of food from a preparation table and walked back out of the kitchen without wearing a hair net, bicket up a tray of food from a preparation table and walked back out of the kitchen without wearing a hair net, bicket on yet ray and OSM # 4. When asked if a hap proximately 12:30 p.m. an interview was conducted with OSM # 4 stated, "Yes. I stood in the doorway and asked for my tray and OSM # 4. When asked if a hap proximately 12:30 p.m. an observation was made that a non-delay staff member came into				1			
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F 371 Continued From page 20 and server food in a sanitary manner 1) Facility staff failed to wear heir restraints in the main kitchen during food preparation and serving. 2) Facility staff failed to ensure uncovered food was free of dust and debris from a nearby fan. The findings include: 1) On 4/15/15 at 11:52 a.m., the kilchen four was conducted. On 4/15/15 at 11:52 a.m., an observation was made that OSM (other staff rembert) #3. It deletary manager was incl wearing the appropriate hair restraint. On 4/16/15 at 12:20 p.m. OSM (other staff rembert) #3. It deletary manager was the appropriate hair restraint. On 4/16/15 at approximately 12:30 p.m. an interview was conducted the kitchen without wearing a hair net, proked up a tray of food from a preparation table and walked back out of the kitchen. On 4/16/15 at approximately 12:30 p.m. an interview was conducted with OSM #4 stated, "Yes." I stood in the doonway and asked for my tray and (OSM #3), delatary manager fold into to come that to the kitchen without wearing a hair net, proked up a tray of food from a preparation table and walked back out of the kitchen and get in y tray. On 4/16/15 at 12:23 p.m., an observation was made that OSM #4 stated, "Yes." I stood in the doonway and asked for my tray and (OSM #3), delatary manager fold into to come that the kitchen without wearing a hair net, proked up a tray of food from a preparation table and walked back out of the kitchen and get in y tray. On 4/16/15 at 12:23 p.m., an observation was made that a formal properties and get my tray. On 4/16/15 at 12:23 p.m., an observation was made that and path my tray.	W1414E#*154	MONDING CENTER			AMELIA, VA 23002		
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NAME OF	PROVIDER OR SUPPLIER	больной обо «И то намен вывычайными обыч», м оничатом то мен туруулу монен на улуунун үнүү үнү үнү үнү үнү үнү үнү үнү ү		STREET ADDRESS CITY, STATE, 20 CODE	COMPRESSOR AND A MASON CONSIDERA	700 mm mm m m m m m m m m m m m m m m m
ANACLIA	NURSING CENTER		-	8830 VIRGINIA STREET		
PM 1815_1_1PM	MUNDING GERIER			AMELIA, VA 23002		
FREETX TAG	TEACH DEFICIENCY	JEMENT OF DEFICIENCES MUST HE PRECEDED BY FULL SCIDENTIFYING INFORMATION	PRESIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LOBE 0	(80) OMNE (60) trail
F 371	assistant was obserget tea without a hapreparation.	ip.m., a certified nursing rved coming into the kitchen to ir restraint during lunch	F 31	71 3a. In-service for all staff regarding entering kitchen area-must wait door/window for whatever they need. Dietician to in-service dietary. QA to in-service nursing. Administrator to in-service Housekee	: at	1/2015
	conducted with OSI was not wearing a histories she stated," worked at a differential did not have to wea up in a tight bun. "Ween working at this "Thirteen years." A property was not been working at the conduction of the conduct	p.m., an interview was M #3. When asked why she hair restraint while in the Eighteen years ago when I if facility their policy stated I in a hair restraint if my hair was hen asked how long she had a current facility she stated, colley was requested on hile preparing and serving		Laundry, Maintenance, and Rehab 3b. In-service for all dietary staff regal proper cleaning of all food selection equipment especially the meat slicer with given by Dietician. Schedule for cleaning the evaluated by Dietician at the time recommendations made where necessal	od/29 vill be ng to e and	0/2015
	food. On 4/16/15 at 5:00p 12 VAC 5-421-240 d licensure handbook	.m., OSM #3 provided section of the state regulation		3c. In-service for dietary and mainter regarding importance of cleaning fan w or sooner if needed and importance of proper procedure of proper storage of during preparation. In-service to provided by Dietician.	eekly 04/29 using food)/2015
	section, food employ restraints, such as his beard restraints, and hair, that are design keep their hair from clean equipment, ute	led under section B of this yees shall wear their hair ats, hair coverings, or nets, I clothing that covers body ed and worn to effectively contacting exposed food; ensits, and linens; and		4a. Dietary Manager, Dietician, Administrator will check to make sur dietary staff are wearing proper restraints/nets and that no unauthor persons are entering the kitchen prepara	hair prized)/2015
	B. This section does such as counter staf and wrapped or pact wait staff of they pre- contaminating expos	not apply to food employees f who only serve beverages kaged food, hostesses, and sent a minimal risk of led foods; clean equipment, and unwrapped single		b. Dietary Manager/designee daily oversee cooks and cleanliness of all service equipment and sign off on cle schedule. Dietician will do a weekly through and do the same.	food ^{04/27} aning	/2015

FORM CMS-2557(02/99) Previous Versions Obscieve

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If continuation sheet Page 22 of 37

PRINTED: 04/23/2015 FORM APPROVED OMB NO. 0938-0391

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:			IX2) MULTIPLE CONSTRUCTION (X) A BUILDING		
	495358	B WING	· · · · · · · · · · · · · · · · · · ·	04/16/2015	
NAME OF PROVIDER OR SUPPLIE	?	STREET ADDRESS, CITY STATE, ZIP CODE			
AMELIA NURSING CENTER			830 VIRGINIA STREET AMELIA, VA. 23002		
PREFIX (EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	AGRETTANDS 38.0	
	this terminate and a second or	and the second consequence of the state of the state of the second of the second of the second of the second of	**************************************	THE REPORT OF THE PROPERTY OF	

F 371 Continued From page 22 service and single-use articles."

On 4/16/15 at 5:30 p.m., the administrator was made aware of the above findings.

2) On 4/15/15 at 11:56 a.m., debris was observed was left on the blade of the meat slicer that was stored and ready for use.

On 4/15/15 at 11:56 a.m., an interview was conducted with OSM #3. When asked if the meat slicer was clean and ready to be used she stated, "Yes." When shown the debris she stated," It has to be cleaned again." When asked to clarify is she had previously stated that the meat slicer was ready to be used she stated," Yes, that is what I said." When asked the cleaning schedule of the meat slicer she stated, "After every use."

On 4/16/15 at 4:29 p.m., a procedure and cleaning schedule was requested for cleaning the meat slicer.

The facility's procedure for cleaning the meat slicer documented that it should be cleaned immediately after use.

- "1. Turn off and disconnect.
- 2. Remove food tray by loosening the screw on the side of the slicer.
- 3. Remove rectangular glide by lifting out (may be necessary to use a little force).
- 4. Remove the shield that covers the blade; pull latch to remove the cover.
- 5. Wash all parts in hot soapy water.
- 6. Sanilize with accepted water.
- 7. Wipe of remaining parts thoroughly in hot detergent water.

F 371

c. Dietician will also note on weekly note fans are clean and free of debris and proper procedure is being used during food preparation. 05/01/2015

FORM CMS-2567(02-99) Previous Versions Cospiete

Event ID: ZH6F11

Facility ID VA0002

If continuation sheet Page 23 of 37

PRINTED: 04/23/2016 DEPARTMENT OF HEALTH AND HEMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0038-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIFR/CLIA FAC MULTIPLE COMSTRUCTION OCH GAZE BUSEVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A BEJUDING COMPLETED 495358 B WING 04/16/2015 NAME OF PROVIDER OR SUPPLIER

AMELIA NURSING CENTER

STREET ADDRESS, CITY, STATE ZIP CODE

8830 VIRGINIA STREET AMELIA, VA 23002

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SUMMARY STATEMENT OF CEFFILLNOISS (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

PREFIX TAG PROVIDERS PLAN OF CORRECTION LEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(XX) CCA45] ETR)5; (IA15

F 371 Continued From page 23

8 Rinse thoroughly..."

The Main Kitchen cleaning schedule documented that the meat slicer should be cleaned after use

On 4/16/15 at 5:30 p.m., the administrator was made aware of the above findings.

3) On 4/15/15 at 12:15 p.m. It was observed that two ladder racks containing 14 trays were placed in front of a circulating fan that was covered in dust. All trays contained cups of uncovered peaches.

On 4/15/15 at 12:21 p.m., OSM # 3 was asked to turn off the fan and describe what she sees. She stated, "I can tell you it is dirty before I turn it off." She then pulled the cord from the outlet to shut off the fan. When asked to describe what she sees she stated, "Yes it needs to be cleaned. Mainteriance comes in once a week to clean." When asked if the trays with cups of uncovered food items in front of the dusty fan are a problem she stated, "Yes."

On 4/15/15 at 12:45p.m, it was observed that the two ladder racks of 14 trays had been moved away from the fan.

On 4/16/15 at 4:29 p.m., a procedure was requested on proper storage of food during preparation.

On 4/16/15 at 5:00 p.m., a procedure could not be provided on proper storage of food during preparation

On 4/16/15 at 5:30p.m., the administrator was

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PRINTED: 04/23/2016 FORM APPROVED OMB NO. 0938-0391

C. 18 8 1	ACT LANGE THE THE CALCULATION	GERALTARYARY OF LEADING 12			and the same and the	31717 173	
STATEMENT OF DEPICENCES AND PLAN OF CORRECTION		(K1) PROVIDERIGATION NUMBER IDENTFICATION NUMBER	(x2) MULTIPLE CONSTRUCTION A BUILDING			Y BYRIJR BTAG ICKI CET B PHIOD	
	•	495358	E WING		W. W. V. Vanner	0	4/16/2015
KAMI OI I	PROVIDER OR SUPPLIER	Brussen 2019 2011 (** 1945 - 1945) (** 1945) (.4	L LAGES	TACIORESS CITY STATE ZIP CODE	(300°10 (45°14°10°1°10°10°10°10°10°10°10°10°10°10°10°1	<u>anned annel de estado o periodo de estado en estado</u>
A B 55° I 1 A	ADDITION OF AUTOM		36	830 V	/IRGINIA STREET		
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F 371	Continued From pa	ge 24	F 371				
	made aware of the	above findings.					
	483.60(c) DRUG RI IRREGULAR, ACT	EGIMEN REVIEW, REPORT ON	F 428	1.	A discussion by the DON with consultant pharmacist and to	he IT	04/23/15
reviewed at		of each resident must be nice a month by a licensed			department at Omnicare reveale the consultant pharmacist had re- Resident #5 medications regime be failed to check a block on the for	viewed out had	
	the attending physic	st report any irregularities to cian, and the director of reports must be acted upon,			would generate a report the Resident #5's name was left original list of residents seen pharmacist on November 25, 201 consultant pharmacist then fai document in the progress because the name was not of	off the by the 4. The led to notes	
	This REQUIREMEN	IT is not met as evidenced		2.	original list. The facility changed pha	armacy	
	Based on staff inter and facility documer that the facility staff wrote the monthly m	rview, clinical record review, nt review, it was determined failed to ensure the pharmacy nedication regimen review in or 1 of 25 residents in the ident #5.		2.	providers in November 2014 afte Pharmacy went out of busines medications regime reviews audited from November 2014 to 2015 by the DON and QA nu ensure all reviews had been comp	r APEX s. All were o April rse to	04/29/15
		e pharmacy failed to write the regimen review for November record.		3.		v lists macist ind to	04/27/15
	The findings include	Ğ.			DON or Designee.		
	1/22/15 with the diag strake, pneumonia, unnary retention, dy high blood pressure	ost recently readmitted on gnoses of but not limited to metabolic encephalopathy, sphagia, aphasia, diabetes, , and acute renal failure. The dinimum Data Set) was a					

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AMELIA NI	JRSING CENTER			8830 VIRGINIA STE AMELIA, VA 230	and the 4		
(XA) (0 PRELX		TEMENT OF DEFICIENCIES VAUSTIBE PRECEDED BY FULL	io Posex		ER'S PLAN OF CORRECTIVE ACTION SHO		(ES) COMPETIONS

F 428 Continued From page 25

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quarterly assessment with an ARD (Assessment Reference Date) of 2/3/15. The resident was coded as being severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for transfers. eating, and bathing, extensive assistance for dressing; as having a catheter for bladder and as incontinent of bowel.

REGULATORY OR LSC IDENTIFYING INFORMATION)

A review of the clinical record failed to reveal a note from the pharmacy indicating the monthly medication regimen review had been conducted for November 2014. On 4/16/15 at approximately 10:00 a.m., the Director of Nursing (DON) was asked for evidence the pharmacy reviewed the record in November 2014. A "Consultation Report" listing all residents records that were reviewed on 11/25/14 was provided. The list was in alphabetical order by last name and Resident #5 was not on the list.

Ch 4/16/15 at 6:20 p.m., the administrator and director of nursing were made awars of the above findings. On 4/17/15 at approximately 10:00 a.m., the Director of Nursing (DON) provided a second list that was sent to them by the pharmacy after the facility was notified there was no evidence the pharmacy reviewed Resident #5's drug regimen in November 2014. The second list also identified the residents seen on 11/25/14 as the first list had, only now the second list included the name of Resident #5. When asked about the discrepancy between the lists if the pharmacy saw the resident or not, the DON did not know why the two lists provided by pharmacy were not in agreement regarding who the pharmacy did or did not review on 11/25/14. When interviewed regarding evidence of a note in

F 428

TAG

The consultant pharmacist will report to QA committee quarterly on number of MRRs completed as compared to census for the previous quarter.

CROSS-REFERENCED TO THE APPROPRIATE

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F 428	A review of the facil Regimen Review (A Consultant Pharma required under a Ph Agreement." Hand documented, "Cont on all residents."	ge 26 hat the review was conducted, e didn't have anything else, ity policy "Medication MRR)" documented, "1. The cy will conduct MRRs if larmacy Consultant written under this was ract requires monthly MRRs	F [∞] €	128			
	SPREAD, LINENS The facility must es Infection Control Pro- sefe, sanitary and o to help prevent the o of disease and infect (a) Infection Control The facility must est Program under white (1) Investigates, cor in the facility; (2) Decides what pro- should be applied to	Program ablish an Infection Control th it - atrois, and prevents infections accedures, such as isolation, an individual resident; and and of incidents and corrective	F	141	 Ice scoop now being properly when not in use. Ice holder attacice machine. All ice scoops checked for storage when not in use by Didietary manager or designee Initial off on cleaning schedule. In-service of all dietary staff reproper storage of ice scoop provided by dietician. Ice scoop to be checked daily for storage when not in use by distaff and weekly by Dietician. 	othed to 04/27/15 proper etician, daily. 04/27/15 garding will be proper 04/27/15	
	(b) Preventing Sprei (1) When the Infecti determines that a re prevent the spread (isolate the resident.				1. The QA nurse returned from edical absence and the reviewed the deficient point with the QA nurse regarding infection control log.	om her e DON practice	

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If continuation sheet Page 27 of 37

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STATEMENT OF DEFICIENCIES AND 14 AN DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION RIMBER	(XS) MULTIPLE CONSTRUCTION A BUILDING	(X3) DATE SURVEY COMPLETED
	495358	8 Wifx)	04/16/2015
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, OUTY STATE, ZIP CODE	The state of the s

AMELIA NURSING CENTER

8830 VIRGINIA STREET

AMELIA, VA 23002

(X/H)(C) PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES FACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR USC IDENTIFYING INFORMATIONS

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PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION \$100LD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)

COMPLUCE.

4/27/15

F 441 Continued From page 27

communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.

- (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.
- (c) Linens

Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced bv:

Based on observation, staff interview and facility document review, it was determined that the facility staff failed to maintain a complete infection control program as evidenced by incomplete infection control tracking logs from March 2014 through August 2014; and falled to follow infection control practices for 1 of 3 facility ice machines, and failed to follow infection control practices for 2 of 6 residents in the medication administration observation; Residents #13 and #14.

- The facility failed to maintain complete infection control tracking logs from March 2014 through April 2015, the logs did not include documentation of date of infection identified, resolved dates, cultures, signs/symptoms, or any type of isolation precautions utilized if necessary. In addition there was no log provided at all for the months of July and August 2014.
- Facility staff failed to ensure proper storage of an ice scoop in 1 of 3 facility ice machines

F 441

Cont Part 1

- 2. A new tracking log tool has been developed to include resident name, age, unit, room #, admission date, attending infection M.D. date identified, resolved date, diagnosis, infections site, signs and symptoms, cultures/diagnostic test, used, pertinent remarks, isolation (if any) invasive procedures, risk factors, resident outcome, preventive measures, This will be completed by the infection control nurse or designee.
- 3. The infection control nurse will provide an infection report and tracking and trending to the DON on a monthly basis.
- 4. The QA Committee will monitor the infections control reports quarterly.

04/29/15

04/29/15

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Facility ID VAIRID2

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		TAND HUMAN SERVICES E.S. MEDICAID SERVICES			(PRINTED: 04/23/2019 FORM APPROVEI OMB NO 0938-039
	TO DEFICIENCES OF CORRECTION	(XT) PROVIDERISUPPLIERICEIA IDENTIFICATION NUMBER.	i	PLE CONSTRU		(X3) DATE SURVEY COMPLETED
		495358	B WING			04/16/2015
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AMELIA	NURSING CENTER			8830 VIRGIN AMELIA, V		
(M) (C) PREFIX TAC	(EACH DEFICIENC	ATEMENT OF DETECHICES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	in Przecik Tajs	(机会)	FOUDER'S PLAN OF CORRECTI CH CORRECTIVE ACTION SHOUL S-REPERENCED TO THE APPRO DEPICIENCY)	LOBE COMPLISON
F 441	Cantinued From pa (kitchen),	nge 28	Faa	Part 3		
	The findings include: 1 Review of the facility "Infection Control Log" for March 2014 through April 2015 revealed the following: From March 2014 through August 2014, nurse's note paper was used as the log			1.	LPN # 1 received 1-1 counseling regarding her failure to maintain infections control standards while administering medications.	04/21/13 1
	first initial, last nam diagnosis the antibi were no specific co marked and identific documentation of d resolved dates, cult type of isolation pre	as documented room number, e, antibiotic used and the otic was prescribed for. There flumn and headings of any kind ed. There was no ate of infection identified, ures, signs/symptoms, or any cautions utilized if necessary, is no log provided at all for the		2.	Infection control standards for medication administration were reviewed with the LPNs and RNs by the DON. Monthly medication pour and pass will be monitored by the QA nurse and the	04/29/15
	on 4/16/15 at 3:03 pool (Director of No infection control nur and she was not aw that was being utiliz requested by survey the infection control	August 2014. p.m., in an interview with the ursing) she stated that the se was out for health reasons; ware of the tracking method ed until the logs were wors. She stated that since nurse was out and unable to she was not going to say		4.	pharmacy consultant nurse. The QA committee will monitor the monthly results at the quarterly meeting.	04/29/15
	Nosocomal Infection "Procedure4 College	ty policy "Surveillance for ns" documented, act the following data as "" indicates required				The control of the co

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information.); a. Identifying information (i.e.: resident's name, age, room number, unit and attending physician); b. Diagnosis (resident may have many, list all that apply), c. Admission date, date of onset of infection* (may list enset of

Event to ZH&E11

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If continuation sheet Page, 29 of 37

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	A BUILDI	TIPLE CONSTRUCTION NO	3	ATE SUPVEY OMPLETED
		495358	D WAS		0,	4/16/2015
Andrews and a second	PROVIDER OR SUPPLIER NURSING CENTER		TOTOTO WATER AND	STREETADDRESS, CTY, STATE, 78° CODE 8830 VIRGINIA STREET AMELIA, VA. 23002	- с -постоя в постоя (1,600 год. 5	uidi dikakhi valik rachaerer aranan 19 e mi gays ,
(84) KO PREFIX FAG	(EACH DEFICIENC	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	D PRFFD TAG	PROVIER'S PLAN OF CORRES (JULDBE	OMERTION COMERTION
F 441	Continued From pa	ige 29 n, or date of positive diagnostic	F 4	ą į	ge ver Million de salvene e e e e e e e e e e e e e e e e e e	Marie Vapoping VV. 47(d) agr _a de dress von vage ₁₈₈₉ agradu

lests); d. Infection site! (be as specific as possible, i.e., cutaneous infections should be listed as "decubitus, left foot", pneumonia as "RUL (right upper lobe), etc.); e. Pathogens"; f invasive procedures or risk factors (i.e.; surgery, invasive lubes, Foley, etc., fractured hip, malnutrition, altered mental status, etc.); g. Pertinent remarks (supportive information, i.e.; temperatures, other symptoms of specific infection, while blood cell count, etc.) Note: Change in mental status is often the only precursor to infection in the resident. Also record if the resident is admitted to the hospital, or expires. h. Preventive measures and comments* (interventions, steps taken that might have decreased risk, or would do so in the future (i.e.; barrier techniques, efforts to prevent immobilization, head elevated during tube feedings, resident non-compliance, etc.)).

On 4/17/15 at 8:45 a.m., the Administrator was made aware of the above findings. No further information was provided by the end of the survey.

2. Facility staff failed to ensure proper storage of an ice scoop in 1 of 3 facility ice machines (kitchen).

10n 4/15/15 at 11:52 a.m., the kitchen tour was conducted. On 4/15/15 at 11:59 a.m., an ice scooper was observed sitting on top of the ice in the kitchen ice machine.

On 4/15/15 at 11:59 a.m., an interview was conducted with OSM (other staff member) # 3. The dietary manager. When asked if the ice scooper should be stored on the ice in the ice.

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Facility ID VA0502

If continuation sheet Page, 30 of 37

PRINTED: 04/23/2016 FORM APPROVED

OMB NO. 0938-0391

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		495358	8 WING	or commence and a second or commence of the	04/16/2015
	ROVIDER OR SUPPLIER		8:	TREET ADDRESS, CITY, STATE, ZIP CODE 830 VIRGINIA STREET MELIA, VA. 23002	ing 199 9 (Maria Maria M
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F 441 Continued From page 30

machine, she stated, "Yes, the county health department told us to keep the scooper speared into the ice throughout the day. At the end of the day we sanitize and put it in a zip lock bag." When asked to provide clarification on storage of the ice scoop she stated," I will do my best to provide documentation."

On 4/15/15 at 12:49 p.m., OSM # 3 could not provide documentation on proper storage of ice scoops. She provided a number for the county health inspector. When asked if OSM # 3 knew the federal regulation on proper storage of ice scoops, she stated. "Well I don't know that regulation."

On 4/16/15 at 12:40 p.m., an observation was made that the ice scooper was lying on top of the ice in the ice machine (kitchen).

On 4/16/15 at 1:00 p.m., a dietary aide opened the ice machine, grabbed the ice scooper, filled a piloher of ice and then placed the ice scoop on lop of the ice in the ice machine.

According to the 2013 FDA regulation 3-304.12: in Use Ulensils, Between Use Storage.

"Ouring pauses in FOOD preparation or dispensing, FOOD preparation and dispensing UTENSILS shall be stored:

(E) in a clean, protected location of the UTENSILS, such as ice scoops, are used only with a FOOD that is not TIME/TEMPERATURE CONTROL FOR SAFETY FOOD.

43. In-use utensils: property stored

F 441

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Event ID ZHAFTI

Facility ID VARGOS

Il continuation sheet Page 31 of 37

PRINTED: 04/23/2015

FORM	APPROVED
TMR NO	0018_0101

MEINICIAO LON MEDICIAM	G MEDICAID SEKAICES		MB NO. 0938-03			
STATEMENT OF DEFICIENCIES (X.1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION DENTIFICATION NUMBER		CARL MULTIPLE CORRESTRUCTION CONDITION CONDITION CONTROL CONTR	(X3) DATE SURVEY FRAMPLETED			
	495358	B WING	04/16/2015			
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		FREG WORLNIA STOREY				

AMELIA NURSING CENTER

AMELIA, VA 23002

(84) 63 PREFIX î A

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR USO IDENTIFYING INFORMATION;

:0 PREFIX TAG

PROVIDER'S PLAN OF CORRECTION LEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

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F 441 Continued From page 31

Based on the type of operation, there are a number of methods available for storage of in-use ulensils during pauses in food preparation or dispensing, such as in the food, clean and protected, or under running water to prevent bacterial growth. If stored in a container of water, the water temperature must be at least 135 degrees Fahrenheit. In-use utensiis may not be stored in chemical sanitizer or ice between uses. Ice scoops may be stored handles up in an ice bin except for an ice machine."

On 4/18/15 at 5:30 p.m., the administrator was made aware of the above findings. No further documentation was provided at that time.

LPN (licensed practical nurse) #1 dropped a pill on the medication cart, picked the pill up with her bare hand, placed the pill in a medication cup and administered the plit to Resident #13.

Resident #13 was admitted to the facility on 3/20/13 with diagnoses that included but were not limited to: diabetes (elevated blood sugar), kidney disease and high blood pressure. Resident #13's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/23/15, coded the resident as being cognitively intact.

On 4/16/15 at 8:12 a.m., observation of LPN #1 preparing and administering medication to Resident #13 was conducted. During preparation, LPN #1 dropped a pill on the medication cart, picked the pill up and placed the pill into a medication cup, the pill (in addition to other pills) was administered to Resident #13.

F 441

FORM CMS-2567/02-991 Previous Versions Obsolete

Event ID ZHöfft!

FARMLY ID VADGO2

If continuation sheet Page 32 of 37

PRINTED: 04/23/2015

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OMB NO.	0938-0394

	U- DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDING	E CONSTRUCTION	COMPLETED
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AMELIA NURSING CENTER			1	330 VIRGINIA STREET MĒLIA, VA. 23002	
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On 4/16/15 at 10:35 a.m., an interview was conducted with LPN #1. LPN #1 was asked what should be done when a pill is dropped on the medication cart. LPN #1 stated the nurse should dispose of the pill and get another pill. LPN #1 confirmed she administered Resident #13 a pill she had dropped on the medication cart that morning,

On 4/16/15 at 6:20 p.m., the administrator and director of nursing were made aware of the above findings. A policy regarding this matter was requested. The policy provided was tilled, "ADMINISTRATION OF MEDICATIONS" and failed to document any pertinent information regarding the above findings.

4. LPN (licensed practical nurse) #1 dropped a pill on the medication cart, picked the pill up with her bare hand, placed the pill in a medication cup and administered the pill to Resident #14.

Resident #14 was admitted to the facility on 7/10/13 with diagnoses that included but were not limited to: high blood pressure and heart disease. Resident #14's most recent MDS (minimum data sel), a quarterly assessment with an ARD (assessment reference date) of 1/14/15, coded the resident's cognition as being severely impaired.

On 4/16/15 at 8:00 a.m., observation of LPN #1 preparing and administering medication to Resident #14 was conducted. During preparation, LFN #1 dropped a pill on the medication cart, picked the pill up and placed the pill into a medication cup; the pill (in addition to other pilis) was administered to Resident #14.

F 441

FORM CMS-2567(02-99) Previous Versions Obsidera

Event ID. 2H6FT1

Facility ID VACCOS

if continuation sheet Page 33 of 37

PRINTED: 04/23/2019 FORM APPROVED OMB NO. 0938-0391

AMELIA NURSING CENTER AMELIA, MARCIA,	
MAME OF PROVIDER OR SUPPLIER AMELIA NURSING CENTER AMELIA, MARCHA, M	RESS CITY, STATE JIP CODE
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	ROVIDER'S PLAN OF CORRECTION (AV) CH CORRECTIVE ACTION SHOULD BE CHARLETION S-REFERENCED TO THE APPROPRIATE SATE DEFICIENCY)
F 514 483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments, the plan of care and F 514 regardoccuraters doccuraters #2 sherically accessible; and state doccuraters as a second of the resident; a record of the resident's assessments, the plan of care and 2. RN:	3 and LPN#2 were interviewed ding the conflicting mentation on Resident #2 flu pneumovac records under ent documents and in Resident rogress notes and observation in the electronic chart. LPN#2 d she had signed in error. The ment was corrected by LPN #2 documentation error. Resident fused both vaccines. 3 did a 100% audit of all flu and movac given in 2014 to ensure
preadmission screening conducted by the State; app and progress notes. 3. The pne This REQUIREMENT is not met as evidenced by: nurs 8ased on staff interview and clinical record electric elect	priate documentation. protocol for the flu and 04/20/15 movac documentation will limit mentation to the electronic ng progress notes and the ronic form titled enza/Pneumococcal

FORM CMS-3587(92-99) Presidus Versions Obsolute

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Facility ID: VA0002

If continuation sheet Page 34 of 37

DEPARTMENT OF HEALTH AND HUMAN SERVICES OFNITERS FOR MEDICARE & ME

PRINTED: 04/23/2015
FORM APPROVED
COMP NO 0628.0361

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, 0.1			FS	4.	. The	QA	Committee	will	04/29	9/15
		vey sample, Resident # 2. le facility stalf falled to		m	onitor	vaco	inations at	the		
		nt the influenza and		qı	uarterly	meet	ings.			
	pneumococcal imm									
	The findings include									
		dmitted to the facility on								
	11/27/12 with a read	dmitted on 12/1/14 with								
		ided but were not limited to:								
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	aneurysm (a bulge)									
		an artery), osteoporosis (makes your bones weak								
	and more likely to b									
		ronary arlery disease								
		eart disease) and dementia (a caused by disorders that								
	affect the brain).	caosed by distribute that								
		# 2's electronic clinical record								
		Facility) Vaccine Record."								
		eumococcal)-Vaccine" it								
		e given, "9/14 (September								
	2014)." Under "Flu	(influeriza) Vaccine" it								
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	· . · · · · · ·	ew of Resident # 2's								
	electronic clinical red									
	"Influeriza/Prieumoc									
	Observation Report.									
	"Influenza/Pneumoc									
	Observation Report"	ent refused pneumo								
	(nagamariag, Near)	cine a! this time. Resident								
	educated on pneum	o vaccine and the importance								
		Slated, 'Go away. I don't care								
		s. Leave me alone." The								
	"influenza/Pneumoco									
	Observation Report"	dated 11/24/2014								
		ent rejurned from hospital								

FORM CNS 2507(03:39) Previous Versions Obsolete

stay on 11/21/14. Offered flu (influenza) vaccine

Event iO: 2H6F11

facility ID VADDOZ

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PRINTED: 04/23/2015 FORM APPROVED

OMB NO. 0938-0391

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AMELIA N	URSING CENTER			830 VIRGINIA STREET MELIA, VA. 23002	
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F 514

upon return from the hospital. Resident refused flu vaccine at that lime."

The "Resident Progress Note" dated 9/25/2014 at 11:20 a.m. for Resident # 2 documented, "Resident refused pneumo vaccine at this time. Resident educated on pneumo vaccine and the importance of receiving it. She stated, 'Go away. I don't care what you say. Leave. Leave me alone."

The "Resident Progress Note" dated 11/24/2014 at 9:33 a.m. for Resident # 2 documented, "Resident returned from hospital stay on 11/21/14. Offered flu (influenza) vaccine upon return from the hospital. Resident refused flu vaccine at that time."

On 4/17/15 at 8:45 a.m. an interview was conducted with RN (registered nurse) # 3. When asked who tracked the immunizations RN # 3 stated, "I do." When asked about the discrepancy of the two immunization records for Resident # 2, RN # 3 stated, "(Resident # 2) refused the vaccines." When asked about the "(Name of Facility) Vaccine Record" that documented Resident # 2 received the immunizations, RN # 3 stated, "It was documented in error by (LPN (licensed practical nurse) # 2).

On 4/17/15 at 8:50 a.m. an interview was conducted with LPN # 2. LPN # 2 stated she had documented that Resident # 2 had received the influenza and pneumococcal vaccines in error. The facility's policy "Medical Records" documented in part, "All records are complete and accurate."

The Administrator and DON were made aware of these findings on 4/17/15 at approximately 10:00 a.m.

FORM CMS-2567(02-99) Previous Versions Obselled

Event ID: Zh6Ft1

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